

## WCFU-Revision 04/14/05

Side 2.....Claim Referral / Initial Information Report

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CLAIMANT:

DWC Claim No: \_\_\_\_\_ SSN: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

EMPLOYER:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Telephone: \_\_\_\_\_

INSURANCE CO:

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Extension: \_\_\_\_\_

Claim #: \_\_\_\_\_ Body Part(s): \_\_\_\_\_

Adjuster: \_\_\_\_\_ Extension: \_\_\_\_\_

INCAPACITY:

1<sup>st</sup> Incap. From: \_\_\_\_\_ To: \_\_\_\_\_

2<sup>nd</sup> Incap. From: \_\_\_\_\_ To: \_\_\_\_\_

3<sup>rd</sup> Incap. From: \_\_\_\_\_ To: \_\_\_\_\_

INFORMATION:

Marital Status: \_\_\_\_\_ Dependents: \_\_\_\_\_

AWW: \_\_\_\_\_ Comp. Rate: \_\_\_\_\_

CLAIM STATUS:

Open / Closed \_\_\_\_\_ Total/Partial: \_\_\_\_\_

Non-Pred/Date: \_\_\_\_\_ Term./Date: \_\_\_\_\_

MOA/Date: \_\_\_\_\_ Susp./Date: \_\_\_\_\_

Settlement/Date: \_\_\_\_\_ Decree (WCC#): \_\_\_\_\_

DATE OF BIRTH:

\_\_\_\_\_

PREVIOUS INJURY: No / Yes

DOI: \_\_\_\_\_ Claim#: \_\_\_\_\_

DOI: \_\_\_\_\_ Claim#: \_\_\_\_\_

## ACTIVITY/ALLEGATION - (Continued)

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.